[EXHIBIT N]

[Carrier]

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type Policy number ([Carrier] Use Only)

New Policy Change in Policy Requested Effective Date _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company):_____
2. Tax Identification Number:_____
3. Main Address:_____
   Street City State Zip
   Mailing Address:_____
   Street City State Zip
   Telephone: ( )_____ Facsimile: ( )_____
4. Name of Correspondent:_____
5. Type of organization: Corporation Partnership
   Proprietorship Other (explain):_____
6. Nature of business (specify):_____
   SIC Code _____
7. Number of eligible employees in your company: _____

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance Requested For: Employees Only Employees & Dependents
11. Are you subject to the requirements of COBRA? Yes No
12. Waiting period before employees become insured: (may not exceed 6 months)
    Present employees:_____ New or Rehired Employees:_____
13. What percentage of the premium will the employer pay?_____
14. Deposit $_____

Premium Paid: Monthly Quarterly [Automatic checking withdrawal]
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	**No. eligible employees in this company**	**No eligible employees to be insured**

SECTION II: SPECIFICATIONS FOR COVERAGE

[**HEALTH BENEFITS**

Wraparound (Hospital Base Plan ____ days)

Plan: A B C D E HMO HMO-POS Dual Contract POS

Deductible (Options for plans B, C and D only): $250 $500 $1,000 $2,500

High Deductible Options: $ $

Co-Payment (Options for HMO Plans Only): $5 $10 $15 $20 $30

Managed Care Delivery System: PPO POS None

PRESCRIPTION DRUG BENEFITS
Program Type: Card Mail Order Card/Mail Order

MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS
Co-Payment Option: $5 $10 $15 $20

NON-STANDARD OPTIONAL BENEFIT RIDERS

]

[NOTE: COVERAGE UNDER THIS POLICY IS SUBJECT TO THE ALTERNATIVE METHOD FOR COUNTING CREDITABLE COVERAGE]

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
- now in force and to be continued? Yes No
- currently being applied for? Yes No

If "Yes" identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s)

_____

2. Name of present or prior group carrier_____
   Effective date of prior coverage:_____
   Cancellation/termination date:_____
Is the coverage applied for in this application replacing other group insurance?
   Yes No
   If "Yes" give reason_____
   Plan being replaced: A B C D E HMO HMO-POS Dual Contract POS ž
Other:_____

3. Has your firm been uninsured for 3 or more months prior to application?
   Yes No

4. What forms of insurance are now or were in force?
   Health Benefits Prescription Drugs (attach copies of Booklet / Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits?
   Yes No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?
   Yes No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/ Dependent	**Date of Birth**	**Type of Continuation State/Federal/ Extended Benefits**	**Reason for Termination Disability /Other**	**Continuation Dates** **Start** **End**

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge:

   a) Are any employees or dependents presently incapacitated?
      Yes No

b) Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Additional space to explain if Items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____
_
_____
_
_____
_
_____
_
_____
_

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]

SECTION V: SIGNATURE

[It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. [Final rates will be based on enrollment data as of the Policy effective date.] No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at _____ on _____

_____ _____

Print name of Officer, Partner or Proprietor Signature of Officer, Partner or Proprietor

_____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

EXPLANATION OF BRACKETS AND TEXT
APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

1. Contractholder or Planholder and Contract or Plan, as appropriate.

2. The terms Policyholder and Policy may be replaced with terms insurance and insured may be replaced with coverage and covered, as appropriate.

3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.

4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer, including optional benefit riders. For example, if a Carrier does not offer HMO plans, such text may be deleted.

5. Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.

6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.

7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21.7.3(e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.